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ABSTRACT

A model of delivery of psychological services which takes into account the limited availability of trained psychologists in rural communities and which offers advantages in terms of offering career opportunities for the target population is presented. The model de-emphasizes "early identification". (Author/CK)

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Head Start Psychological Services in a Rural Program

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Although Project Head Start's image among laymen and professionals is primarily that of a program which attacks an urban problem, poverty does exist on farms and in rural areas. The thesis of this paper is that the delivery of psychological services to rural programs poses some special problems which do not exist in cities--or if they do exist in cities, it is to a much lesser extent. The solutions which I will recommend may, however, have some implications for urban programs as well.

A typical Community Action Agency in rural America probably serves an area of about 4,000 square miles; the state of Connecticut is 5,000 square miles. In this entire area there is not likely to be anyone with graduate training in Psychology--let alone someone with a Ph.D. in Psychology. This area is typically divided into seven or eight counties, each with a single Head Start classroom. Each of these headstart classrooms may have a "catchment" area as large as 400 square miles; it is not unusual for children to spend two hours a day riding to and from the classroom.

Although my experience has been primarily in Iowa, I assume the situation in states like Montana, Nevada, Arizona is even more extreme. The two major problems then, are the absence of qualified psychologists and the need to travel long distances--often under very difficult driving conditions. Given this situation, I would like to outline what I see as a model Head-start Psychological Services program--"model" in the sense that is feasible, potentially of high quality, and with built-in protection for the consumer.

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The fulcrum of the program is an M.A. psychologist; a person with some graduate training who is aware that he does not have the qualifications for independent delivery of psychological services. This person would be responsible (1) for in-service and pre-service training of the teachers and teacher aides; (2) for on-going consultation with teachers about problems they face in the classroom; and (3) for the occasional psychological evaluations which are necessary for decision making. In addition, and perhaps most important, this person would be responsible for exploring the catchment area and surrounding countryside for mental health resources, so that referral to these mental health agencies could be made for that small percentage of children and families which require and seek further mental health services. This liaison function is in keeping with the Office of Child Development's function of coordinating all federal services for children.

On one side of this fulcrum is a Ph.D. level psychologist, preferably (in my view) a Child Clinical Psychologist with experience in community consultation--I emphasize clinical rather than child, because most of the problems facing a Headstart classroom cannot be fully understood without understanding the total family situation. The Ph.D. person would serve as a consultant to the M.A. psychologist; perhaps 4-6 days a year would suffice. He would also be of assistance in locating and evaluating the mental health resources. Although it is essential that this person be a fully trained, qualified, and licensed psychologist, it is equally important that he or she be fully aware of the fundamental thrust of Headstart: Headstart is part of the war on poverty and its ultimate goal is the overcoming of poverty. The person must combine the academic credentials and the real-world commitment to problem solving. I think we in Headstart have been guilty of allowing non-licensed psychologists to offer psychological services to Head Start children.

Would the federal government countenance the delivery of medical services to Head Start children by people who did not have a license to practice medicine?

On the other side of the fulcrum are paraprofessionals: call them social service aides, mental health workers--I like the term "family service aides". These paraprofessionals--preferably from the target population and located in the local counties--can serve to organize the material about a child and family preparatory to the psychologist's arrival in the area and, more important, do the leg work necessary for follow-up. As a local person, the family service aide can establish a close relationship with those families which need the continuing support of someone who knows "the ropes"--someone who can get services out of the establishment.

This model is financially feasible, takes into account the enormous distances in rural programs, and seems reasonable in terms of available manpower. An added advantage is the built-in possibilities for a new kind of career development ladder. The family service aide is an entry level position. After some experience in this position and with additional education, the candidate can expect to move to a more responsible position. A Head Start teacher, on the other hand, might be pursuing graduate work in Psychology and be moving toward the M.A. level position. The M.A. person might be working toward a doctoral degree.

Before closing I wish to mention one feature of this delivery system which may appear to run counter to current Office of Child Development policy: there is a lack of concern for "early identification". Although "early identification" could easily be integrated into this model, I have some serious reservations ~~about the~~ increasing emphasis on this idea which I think needs to be thought through in greater detail than it has been.

I believe that when we speak of "early identification" we mean that somehow a skilled mental health professional will first label a child as having a serious

psychological problem and then do something (treat, cure, etc.) with that child so that label can be removed. Based on a medical analogy, the implication is that by identifying and labelling the child, it will be easier to alter that child's behavior so that he will not develop a more serious psychological problem--in the same way that the early spotting of a physical problem generally (though, of course, not always) makes it easier to correct that physical problem or cure that physical disease.

The applicability of this model to most behavior problems has been questioned repeatedly during the past several years. The analogy with medical procedures is based on several misconceptions.

The first misconception is that behavior problems of early childhood are hard to identify. This, almost by definition, is not true. Teachers, parents, Head Start volunteers all know which child is biting, kicking, screaming, or withdrawing. The dangers of overlooking an exceptionally quiet, well-behaved child who turns out to be mentally disturbed as an adult are, I believe, largely exaggerated. Furthermore, I do not know of any data which indicates that mental health professionals can do this any better than laymen. Adults who pose problems to society were generally well known to both laymen and mental health professionals as children (Robins, 1966).

The second misconception is that "early identification" leads to better chances of successful intervention. Not only is evidence for this lacking but actually the contrary may be true, and it is the possibility that "early identification" is harmful that I wish to emphasize; this danger can be understood best in terms of Sarbin's concept of "degradation of social identity." According to Sarbin (1968), every person plays many social roles and his enactment of these roles constitute his social identity. His social identity is what others think of him--the label he carries: father, husband, psychologist, member of Kiwanis, and so on. When a person is

labelled mentally ill or criminal, this new role debases him--there occurs a degradation of his social identity.

Labelling a headstart child "as a problem"--i.e., "early identification"--degrades not only the child, but it degrades his siblings, his parents,--in fact, his entire family. Sarbin has data which supports these ideas.

In an optimal delivery system, it seems to me, there should be as little labelling as possible. A good headstart program is good for all children--those with problems and those without problems. The only time we need to worry about "early identification" is when we have reached the point of considering removing the child from the program--when he is so disruptive to the classroom that he cannot be tolerated. At that point, we don't need psychological tests for the child--we need to evaluate the capacity of the Headstart teacher to cope with the disturbances the child creates. Removing the child from the classroom is not usually going to help him.

I wish to point out that de-emphasis on early identification does not mean a lack of concern for preventing problems. Making consultation easily available to teachers, parents, and staff will aid in creating the kind of atmosphere which fosters the ability of all concerned--including the child--to cope with difficult situations. Also, there will always remain some few severely atypical children who require very special attention; we should avoid singling out these children unless we are reasonably certain that the special attention we will give them will more than make up for the negative consequences of labelling them as atypical.

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Summary

I have suggested a model of delivery of psychological services which takes into account the limited availability of trained psychologists in rural communities and

which offers advantages in terms of offering career opportunities for the target population. The model de-emphasizes "early identification" and I have tried to explain why I think it should be de-emphasized.

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